Mentally Ill Offender Community Transition Program

Annual Report to the Legislature
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Annual Report to the Legislature

The Mentally Ill Offender Community Transition Program (MIO-CTP) began in July 1998. This five-year pilot program was created in response to RCW 71.24.450, and was charged with developing post-release mental health care and housing for a group of up to 25 mentally ill offenders entering community living upon release from Department of Corrections (DOC) correctional facilities. The goals of the program are to reduce incarceration costs, increase public safety, and improve the offender's chances of succeeding in the community.

The Department of Social and Health Services (DSHS) Mental Health Division (MHD) contracted with the King County Regional Support Network (RSN) to develop, implement, and administer the pilot program. King County RSN contracted with Seattle Mental Health and its subcontractors, Pioneer Human Services and Therapeutic Health Services, to provide the statutorily required service components. Collaboration throughout the process occurred with DOC.

The program has enrolled a total of 64 participants during the first four years of the five year pilot. As of July 31, 2002, there were 21 active participants in the program. Of the 43 participants no longer in the program over this four year period, nine have successfully completed, graduated and transitioned to the community. Another 13 requested less intensive services and transferred to other mental health programs. The remainder refused services, terminated without notice, or are otherwise no longer involved in this voluntary program. Additional information related to the program is provided in Appendix A.

Services

Participants in the program receive a comprehensive array of services to promote success in their transition to the community. Those services are individualized to the needs of the participant and may include:

- Individual and group mental health and substance abuse treatment
- Drop-in and day treatment
- Special evaluations and consultations
- Medication prescription and monitoring
- Specialized sex offender treatment
- Case management
- Supervised housing

Comparison Groups

One comparison group was used to ensure that participant characteristics are comparable to the broader DOC population. To date, participants in the MIO-CTP project bring essentially the same criminal histories and life problems as represented in this comparison group except that this project has more female and more black participants. Furthermore, the MIO-CTP participants, like other DOC inmate populations, demonstrate considerable substance abuse and personality disorders.

The second comparison group was comprised of mentally ill offenders with similar age, criminal history, mental illness, etc. and was used to test the success of the program. At year four of the project, these are preliminary results. More comprehensive assessment of the results and final analysis will be forthcoming next year. Further detail is provided in Appendix B. The significant results to date are outlined below.

Key Findings

The most important outcome reflected in the data collected to date is that with the organized, intensive post-release services provided to MIO-CTP participants, felony re-convictions are one half of that of a comparison group that did not receive these same services.

In addition, as the detailed appendix shows (Appendix B), over the course of the four years, the program has initiated improvements that have resulted in decreased substance abuse relapse and fewer community corrections violations.

Recommendation

These results suggest that investments in organized, intensive services for high risk, high recidivism populations will produce important savings (primarily for DOC) and increased public safety, often within the same biennium. These data recommend enhanced funding for this and similar programs.

APPENDIX A: - PROGRAM INFORMATION

BACKGROUND

In compliance with RCW 71.24.460, this is the fourth annual report to the legislature regarding the Mentally Ill Offender Community Transition Program (hereafter referred to as the program). RCW 71.24.455 authorizes this five-year pilot. Funding began July 1998.

The Act articulates the legislative intent for the pilot:

> "Many acute and chronically mentally ill offenders are delayed in their release from Washington correctional facilities due to their inability to access reasonable treatment and living accommodations prior to the maximum expiration of their sentences. Often the offender reaches the end of his or her sentence and is released without any follow-up care, funds, or housing. These delays are costly to the state, often lead to psychiatric relapse, and result in unnecessary risk to the public.
>
> These offenders rarely possess the skills or emotional stability to maintain employment or even complete applications to receive entitlement funding. Nation-wide only five percent of diagnosed schizophrenics are able to maintain part-time or full-time employment. Housing and appropriate treatment are difficult to obtain.
>
> This lack of resources, funding, treatment, and housing creates additional stress for the mentally ill offender, impairing self-control and judgment. When the mental illness is instrumental in the offender's patterns of crime, such stresses may lead to a worsening of his or her illness, re-offending, and a threat to public safety.
>
> It is the intent of the legislature to create a pilot program to provide post-release mental health care and housing for a select group of mentally ill offenders entering community living, in order to reduce incarceration costs, increase public safety, and enhance the offender's quality of life." [RCW 71.24.450]

Specifically the Act:

- ☐ Charges DSHS to contract with a Regional Support Network (RSN)

or private provider to provide specialized services for up to 25 mentally ill offenders
- ☐ Sets participant selection criteria
- ☐ Specifies a set of required services
- ☐ Creates an oversight committee composed of representatives from DSHS, DOC and a selected RSN or private provider
- ☐ Requires DSHS, in collaboration with DOC and the oversight committee, to track outcomes and submit to the legislature a report of the services and outcomes by December 1, 1998, and annually thereafter as necessary.

The report to the legislature is to include:
- ☐ A statistical analysis regarding the re-offense and re-institutionalization rate by the enrollees in the program
- ☐ A quantitative description of the services provided in the program
- ☐ Recommendations for any needed modifications in the services and funding levels to increase the effectiveness of the program

The program has been in operation for four years of its five-year projected implementation. This report focuses on program implementation, adjustments, innovations and outcomes. All outcome and evaluation results should still be considered preliminary. This report presents data on the participants, services and outcomes as of July 31, 2002.

PROGRAM IMPLEMENTATION

Oversight Committee

As authorized by statute, the oversight committee is comprised of a representative from the DSHS, DOC and King County RSN. This committee, with a rotating chairperson, operates in a collaborative manner to develop the policies and processes necessary to implement the project. The committee meets monthly to review project activities, discuss and resolve issues raised by program staff and provide project direction and oversight. A recent example of the oversight committee's work is the development of policy to prioritize persons waiting to enter the program.

Program Administration

In August 1998, DSHS contracted with the King County RSN to develop and implement the pilot program. In September 1998, the King County RSN contracted with Seattle Mental Health (SMH) and its subcontractors,

Pioneer Human Services and Therapeutic Health Services, to provide the statutory required service components. The three organizations are licensed mental health and substance abuse agencies with a history of partnership in providing an integrated program of mental health, substance abuse, residential, vocational and community-based correction services.

Program Staffing

Seattle Mental Health uses a multi-disciplinary team approach to deliver integrated treatment services to a broad spectrum of participants. The agency provides services to persons with a variety of clinical diagnoses, levels of functioning and differing degrees of mental health and substance abuse issues. The program staff include case managers, the project manager, psychiatrist, nurse practitioner, registered nurse, substance abuse assessor/counselor, and two residential house managers. Staff members have forensic and clinical experience and are skilled at exercising authority, setting limits, establishing appropriate behavioral standards and integrating supportive treatment and behavioral supervision. Most of these staff members are devoted only part-time to the pilot. The total staffing represents approximately five and one-half full time equivalents**.**

Participant Referral and Selection

In considering candidates for referral to the program, DOC staff evaluates mentally ill offenders against program selection criteria based on statutory mandated elements and good clinical practice. Candidates come from four correctional facilities known as launch sites. Corrections may transfer mentally ill offenders from other correctional facilities to these launch sites for review and consideration. The four launch sites are:

- ☐ Lincoln Park Work Release Program in Pierce County
- ☐ McNeil Island Corrections Center in Pierce County
- ☐ Monroe Correctional Complex in Snohomish County
- ☐ Washington Correctional Center for Women in Pierce County

DOC institutional staff first screens potential candidates for the program and then refer candidates for an interview by program case managers. DOC staff prepare a comprehensive referral packet that includes the legal history surrounding the offender's crime, mental health assessments from psychiatrists and psychologists and associated clinical information for the King County RSN. The selection committee, DOC and King County RSN staff review all information, discuss the candidate with a launch site representative and make the selection decision. The selection of persons

with a history of sex offenses or fire setting continues to be particularly problematic. There are limited options for appropriate housing or proprietors willing to accept these offenders.

PROGRAM COMPONENTS

Coordinated Pre-release Planning

The coordinated pre-release planning component has emerged as a crucial element of successful community integration. This phase begins after the selection committee identifies a referred person as eligible, and while the person is still incarcerated. Ideally this phase is implemented three months before the offender's release date.

Pre-release planning includes several components:

- ☐ Convening of a multi-system team that includes the mental health provider, DOC Community Corrections Officer, prison-based DOC staff, and the chemical dependency provider (when applicable);
- ☐ Developing comprehensive assessments and intakes that incorporate mental health and chemical dependency treatment needs and DOC community supervision requirements;
- ☐ Creating an individualized treatment plan that includes input from the inmate and community-based providers;
- ☐ Applying for entitlements (GAU, SSI, Medicaid) and coordinating start-up with local Community Service Offices;
- ☐ Establishing initial appointments that coincide with the week/day of release;
- ☐ Forming a therapeutic relationship with the offender.

After the initial meetings with the offender and prison-based DOC staff, ongoing coordination of pre-release activities is facilitated through weekly team meetings where issues such as housing needs, medication management, and chemical dependency treatment needs are discussed. The overarching goal is to provide as seamless a transition to community life as possible.

> ***Participant A****: This person was referred to the program with no DOC community supervision. The majority of her life had been spent either on the streets or in jail. She suffers from Schizophrenia, Paranoid Type, and cocaine addiction. Her crimes were related to her drug use. After reviewing her psychiatric record*

and meeting her, it was clear that her cognitive and functional skills were very impaired. Independent living would be out of the question. The mental health provider accepted her into the program in order to place her into a structured living situation, which was considered the best option for a person with her profile. She was screened for group care living, met criteria and within three weeks of release she resided in a supervised living facility. She continues to work with the same MIO-CTP caseworker to reduce the likelihood of clinical disruption. She still continues daily check-in at the mental health provider agency, attends their Clubhouse Program and remains drug free.

The program served a greater proportion of participants with complicated profiles throughout the last year. An increased number of participants presented with complex and multiple psychiatric diagnoses, histories of serious sex offenses, challenging personality disorders, fetal alcohol syndrome, and medical problems. This resulted in the program seeking out innovative and specialized services to address these issues.

Participant B: *This client was diagnosed with Schizophrenia and polysubstance abuse. His criminal history includes armed robbery, firing a weapon, stabbing another person and additional violent assaults. Upon release, he resided at the Berkey House. However, he was unable to remain clean and sober, so he eventually lost his housing. The program continued to work with him by providing outreach and engagement services, and encouraging him to undergo detoxification, which he eventually did. The mental health provider discovered the client had developed a rare form of cancer and immediately sought the necessary medical services. His caseworker coordinated his medical care and accompanied him to all appointments. He underwent successful surgery, has regained his housing, and has refrained from alcohol and drug use since being pain free. He continues to engage in the program and his health is improving on a weekly basis*.

Intensive Post-release Case Management

The first week is a vulnerable time for most participants. It is well documented that participants are highly susceptible to chemical dependency relapse at this time. To mitigate this risk, participants are asked to remain at their residence during the first week, unless accompanied by a case manager or attending a nearby appointment.

On the initial release day DOC staff transports the released offender (now

referred to as "the participant") to his/her housing. In most cases, newly released participants are initially housed at a specialized supported living facility. When the participant arrives, he/she is met by his/her case manager and introduced to the house manager. The participant's first day in the community is typically a busy one. The case manager takes the participant shopping for clothing, bedding, cooking implements, food, cleaning supplies, and personal care items. The participant usually has an intake appointment at the DSHS Community Service Office[1] so that financial resources can be available immediately.

The second day usually includes an appointment with a health care provider, obtaining legal identification, having a DOC community intake appointment, and meeting the program staff members who are part of the participant's team.

During the remainder of the first week, the participant typically has initial appointments with his/her chemical dependency treatment provider and with psychiatric services. Some participants have significant mental health symptoms and/or compromised levels of functioning; consequently, strategies are employed to assist such participants in transition to the community at a pace that is compatible with their abilities. For participants who have limited daily living skills, such as how to shop, cook, or take care of personal hygiene needs, their case manager will immediately provide coaching and skill building. For those who become confused or get lost when trying to get to appointments the case manager will walk with them until they can find their way or are no longer overwhelmed.

The intensity of the first week's activity sets the stage for implementing the ongoing services identified in the participant's individualized treatment plan. As the participants successfully achieve treatment objectives and goals, they are encouraged to become more independent. A transition plan is developed that maps strategy for achieving greater self-determination and reducing dependence on formal systems. Elements of this plan might include living in a less structured housing environment, engagement in educational and employment activities, and increased self-monitoring of medications.

Outreach and Engagement: For some participants, the combination of severe mental illness, past criminal behaviors and other factors, results in significant resistance to engage in the treatment and services needed to achieve individual and community stability. Some are subject to mental

[1] Financial applications are completed while the participant is still incarcerated, but face-to-face intakes are still required before entitlements can be dispersed.

health decompensation, chemical dependency lapse/relapse, and/or periods when the participants' whereabouts are unknown. In these situations, program staff provide outreach and engagement services designed to establish trust in the treatment team and acceptance of services. Staff engage the participant whether in jail, on the streets, in shelters, in hospitals, or in detention by Immigration & Naturalization Services. For some, the intensity of the program is more than they can tolerate, so enrolling them in "mainstream" services may be the best option.[2]

Structured Programming: The program design incorporates attendance at a minimum of five group sessions per week. These groups are lead/co-facilitated by mental health and chemical dependency professionals and by community correction officers. Assertive mental health treatment is tailored to individual needs, and includes at least one group and one individual counseling session weekly, home visits at least two times per month and other structured activities. Counseling sessions focus on relapse prevention, and case management addresses requirements for meeting all court-ordered conditions. The team reports any violations to the community correction officer.

For participants who receive intensive outpatient chemical dependency treatment, specialized groups are provided. Participants are encouraged and assisted to develop natural supports through Alcoholics Anonymous and Narcotics Anonymous. If participants want a faith-based connection, program staff help the participant locate a culturally appropriate faith-based community. Program staff also help participants re-establish family connections, when appropriate.

When participants are first released, their medication compliance is monitored on a daily basis – participants come to the clinician's office where medications are dispensed and the participant is observed taking them. Some participants are actually given a financial incentive to encourage compliance with their medication regime.

Crisis Response: Program staff and DOC Community Corrections Officer have developed a 24-hour crisis response protocol for all participants, each of whom has an individualized crisis plan that identifies risk factors, strategies that address community safety concerns, and recommended interventions. This plan is electronically available to the after-hour crisis response team, and includes access to a community corrections

[2] The program is mandated to serve no more than 25 participants at a time, so moving some participants to less intensive services may provide an opening for participants who can benefit from intensive services.

supervisor (for those participants who have community supervision) who may provide consultation and assistance with interventions as needed.

A number of program participants have histories of rapid decompensation that can foreshadow assaultive behavior. When this appears to be occurring, program staff immediately assesses whether voluntary or involuntary hospitalization is indicated. County designated mental health professionals often provide consultation, including crisis interventions that may mitigate hospitalization or involvement in criminal behavior. In some cases, however, hospitalization is the appropriate option.

Residential Support Services

The program continues to provide a housing subsidy up to a maximum of $6,600 per participant per year. Seattle Mental Health contracts with Pioneer Human Services, an organization specializing in providing housing to former offenders. Most participants are initially housed in a transitional housing facility when they are first released from prison.[3] This facility provides onsite house management, ongoing monitoring of residents, and offices for clinical services. As the participant achieves greater community stability, he/she may be able to move to less structured housing, which is an important step toward further independence.

Some participants are so cognitively and/or functionally impaired that full participation in program activities is not a realistic expectation. It is particularly challenging for these participants to acquire and implement the set of skills needed to live in transitional or independent housing, i.e., shopping, cooking, cleaning. Residential facilities that provide meals and other supports needed for activities of daily living may be a better option. Placement in such facilities allows the program team to focus on helping the participant to improve his/her mental health symptoms and address other immediate treatment needs. When participants achieve greater stability, acquiring activities of daily living and community living skills can then move to the forefront.

Community Safety

Community safety is a high priority for the program. The program team meets with participants a minimum of five times a week and regularly conducts risk assessments. When a participant experiences mental health deterioration that might indicate risk, a psychiatrist sees the participant on

[3] Some participants are excluded because of their criminal history. For example, the transitional house is not accessible to those who have committed a sex offense because of its proximity to a grade school.

an emergency basis. Staff then closely monitor medication compliance and effectiveness, and coordinate with the psychiatrist to stabilize the participant.

The vast majority of program participants have a history of substance abuse or addiction. Relapse among these participants is of special concern, particularly when the participant has a history of engaging in criminal conduct while under the influence of substances. The program staff assesses risk to the community in each instance of relapse.

Community Supervision

The Special Needs Unit of the King County DOC office has assigned a designated Community Corrections Officer to work with the project. Although community supervision is not a requirement for program eligibility, most participants have some level of supervision. This assignment has fostered cohesiveness amongst team members, and collaboration between the treatment and community corrections systems. This collaboration enables treatment plans to assist the participant in meeting community correction requirements. Community supervision appears to have positive impact on successful reintegration due to the unique role the Community Corrections Officer plays on the participant's team.

The Community Corrections Officer:

- ☐ is an integral part of the treatment team;
- ☐ has the authority to arrest/detain participants for infractions, which can provide a strong reminder to participants to comply with conditions of release and avoid re-offense;
- ☐ can add a corrections perspective to crisis response;
- ☐ has the authority to conduct random UA's for participants with histories of substance abuse, or when current substance abuse is suspected – this can lead to pre-emptive interventions that may preclude incarceration;
- ☐ can conduct room searches to locate drug paraphernalia when there are concerns;
- ☐ can make recommendations in disciplinary hearings that include input from the participant's team;
- ☐ can enforce treatment compliance if this is a condition for release.

Participant C: *This example describes what happened when the program accepted a client who had no supervision and was not ready to participate in treatment. The client was diagnosed with Bipolar Disorder with psychotic features. Her crimes included assault and VUCSA (Violation of Uniform Controlled Substance Act). She was*

housed at the Berkey House upon release. During the first weekend of her release, she got high and consequently, during the same weekend there were more relapses by other residents than is typical for this house. Program staff suspected this new client might have brought drugs into the house. However, DOC could not perform a legal room search because this client did not have community supervision requirements. The situation placed other program participants at risk and destabilized those who relapsed. She was eventually located, was hospitalized and program staff reconnected with her. Hospital discharge planning included placement in a group home where she now resides. This client is now working intensely with mental health and chemical abuse treatment staff from Seattle Mental Health. She is now clean and sober, has experienced no additional hospitalizations, and connects with staff on a regular basis.

A particularly valuable role for the Community Corrections Officer is invoking disciplinary measures when a participant violates conditions. One effective strategy involves temporary incarceration at Lincoln Park, a DOC work release facility in Tacoma that has onsite mental health and chemical dependency counselors. The treatment team continues to work with the participant during temporary incarcerations, the participant experiences the placement as less punitive, and the community provider and facility staff are able to coordinate treatment strategies. The work release environment allows the participant to leave the facility for approved reasons while still providing a highly structured setting.

Co-occurring Disorders (Mental Health and Substance Abuse) Treatment

As integrated mental health and substance abuse treatment plays an ever increasing role in the program, SMH became credentialed as a co-occurring treatment provider during the past year. The former chemical dependency provider withdrew from the contract they held with SMH, although they have remained as a resource to the program. The program continues to adhere to an integrated approach, training the additional team members in developing a coordinated treatment plan and approach. The program is now structured such that the SMH team provides most of the substance abuse treatment services, which is possible because two staff persons are co-occurring disorder specialists. These team members are primarily responsible for assessments, individual treatment and group leadership. Other team members focus on motivation enhancement, preventative intervention, trigger identification and encouraging the clients in their progress. Weekly team meetings and having on-site staff increases communication and promotes frequent treatment review. The

above strategies improves the adherence to the Program for Assertive Community Treatment (PACT) model. An additional benefit is the close coordination with Community Corrections around substance abuse issues. Community Correction Officers are able to provide additional CD services[4] through their contracted provider, Civicgenics.

There are special population concerns and characteristics for ex-offender addicts. Previous unsuccessful treatment efforts with chemically dependent offenders in transition have focused on general characteristics that this population shares with all addicts. Ex-offenders present the same entrenched denial systems, lack of knowledge of the health impact of drugs, and continued emotional entanglement with active users and codependency issues that all recovering addicts deal with. It is common for ex-offenders to quickly exit treatment programs that only address these issues.

Successful work with this group of recovering individuals includes strategies that attend to the unique characteristics of ex-offenders. Treatment strategies address:

- The immediate use syndrome – Most offender addicts employ fantasies of using drugs immediately upon prison release to help them cope with the daily routine of prison life. Strategies such as early intervention with offenders (assessments/individual sessions) during the pre-release phase provide a bridge to a life that is not centered on the use of substances.

- Non-incrimination theme – Many offenders avoid discussions about aspects of their personal or family drug use history due to long standing beliefs that discussing this information will lead to incrimination (or incrimination of loved ones) in further crimes. Strategies such as milieu treatment with ex-offenders to come to terms with their past can lead to the abandonment of denial systems.

- Overt compliance – Some offenders have familiarized themselves with recovery jargon but do not truly attempt to make lifestyle changes. Frequent urine -analysis, family involvement, peer group feedback, and the use of non-traditional counseling techniques help participants develop a deeper understanding of drug addiction recovery.

[4] As integrated mental health and substance abuse treatment plays an ever-increasing role in the program, this report provides a fuller description of the substance abuse treatment than has been provided in previous reports.

Although the program participants represent a very small sample of ex-offenders, clear trends point to the success of the specific chemical dependency treatment strategies used with participants enrolled in the program.

Employment Services

While not all of the participants have obtained employment, the involvement of specialized vocational staff increases motivation and interest in becoming more productive. Participants have worked in such varied employment settings as construction companies, dental offices, coffeehouses and restaurants. Some have worked for private industry while others have done volunteer work as a step toward gaining marketable skills. A number of clients have pursued educational programs, such as completion of their GED, dietitian programs, and musical studies. The program connects those who may not yet be able to work or attend school with Emerald House, a clubhouse program sited at SMH. This is a participant run day treatment program. Additional information on employment services is presented in the Innovations section of Program Successes and Innovations (page 17 of Appendix).

Transitions

The pilot project design calls for participants to transition from the intensive service level of the program to the "mainstream" publicly funded mental health system, when it becomes appropriate. Timing of transitions depends on a number of factors: whether the participant continues to have community supervision requirements; the ability of the participant to manage his/her mental health and/or chemical dependency issues without the intensity offered by the program; whether affordable, appropriate housing can be provided without the subsidies provided by the program; and whether the person has requested less intense services.

According to the contract under which this program was established, the King County RSN may immediately terminate from the program any participant arrested, civilly committed under Chapter 71.05 RCW or returned to the physical custody of DOC. Additionally, statutory language allows DOC to terminate other participants as necessary. Terminations typically occur through a process initiated by program staff. Recommended terminations are consistent with statutory requirements and may also include other circumstances, i.e., the participant has disappeared and cannot be located or the participant is Absent Without Leave from a work release facility.

The Program Manager generally presents requests for termination to the Oversight Committee for review and discussion. The Oversight Committee considers whether the request meets statutory requirements, and makes a final determination. Program staff is strongly committed to re-establishing therapeutic relationships with those participants who are willing and able to return to the program. If a terminated participant requests readmission, they are provided with priority review for reinstatement by the Selection Committee, comprised of representatives from provider agencies and DOC.

There were a number of successful transitions from the program this year. The following example describing participant D, is an illustration of a successful transition.

> ***Participant D:*** *This client was a program participant for 18 months. His diagnosis was Psychosis with delusions and poly-substance abuse. His crimes include VUCSA, burglary and theft. The client fully participated in all aspects of the program. Prior to completion of his supervision, he expressed a desire to return to another county where his family resided. Program staff worked with his family to accomplish this transition and helped connect this client with ongoing mental health services in the vicinity. With these transition issues resolved, this client has reunited with his wife and is remaining stable.*

The majority of participants who terminated from the program continue to receive mental health services through the King County RSN, regardless of whether the participant completed the program or left prior to completion. The following is a client who made a successful transition a year ago.

> ***Participant E:*** *This participant's diagnosis is Schizoaffective Disorder, Bipolar Type. His crime was assault. He had a history of 13 involuntary hospitalizations prior to incarceration and his subsequent acceptance into the program. The participant continues to receive services at Seattle Mental Health in the Forensic Mental Health Department. He received a Section 8 voucher (subsidized housing) and was able to apply for and find an apartment for himself. He received an inheritance from an uncle and plans on buying a computer and furnishing the apartment with this money. This participant has been compliant with his medications and has attended all outpatient appointments. He established several good friendships and provides support for some of the current MIO-CPT clients. At the time of this report, this participant is in California for a week pursuing a long time dream: panning for gold.*

The following is a verbatim quotation from a participant who is currently enrolled in the program. This participant requested deletion of all potential identifiers to protect her privacy, therefore we are not including information about her diagnosis or criminal history.

"When I was incarcerated at the Washington Correctional Center for Women I had no idea what I was going to do for my future, in fact to me it was hopeless. I was incarcerated for a very serious crime. To make this situation more complicated I was facing some very serious mental health problems and medical problems. I had no idea how I was going to pay my rent, pay my bills or even feed myself. I felt that no company would hire me, and that I was going to wind up homeless or living with my dysfunctional family. I also had no way to pay for the medical services that I have acquired since my release from prison. The prison had said that the medical problems didn't exist, but after seeing specialists there were even more problems then anticipated. The 6002 Program assisted me with medication management and medications, one on one therapy, a case manager, and group therapy. My case manager assisted me with getting on GAU services with DSHS, and eventually Social Security. They have paid most of my rent. I am responsible for paying 30% of my benefits towards my rent, the rest of it is provided by the program. I am also encouraged to look at my future and to move towards it.

My casemanager helps me with filling out all of the complicated forms for these programs and to check on how I am adjusting to the community. She has helped make sure that I am not alone isolating in my room. Instead she encourages me to reintegrate into society. She also keeps a close eye on how I am emotionally handling this reintegration. She helps me do a monthly budget to make sure I don't overspend my benefits. One of the most important tasks that my case manager does is a home visit at least twice a month. This makes me feel like she really cares how my home life is going.

Since my release I am working a part time job, in stable housing, having my medical issues addressed, and soon to be seeking more permanent housing. Even though some of this had come from me, without the assistance from the program I feel I would have never come this far. Thank you for your time."

Anonymous

PROGRAM SUCCESSES AND INNOVATIONS

Successes

Each year since the program's implementation, new approaches and resources are identified and executed to inform a best practice model for eligible mentally ill offenders. These efforts are often based on particular issues brought to the forefront by the presenting problems or needs of individual participants.

The enhanced ability to work across systems continues to be a major asset toward successful community transition of program enrollees. Representatives from each system have gained considerable knowledge about how other systems work – the mission, goals, regulatory requirements, and activities provided to work with participants. This knowledge, in addition to the personal connections that have been made, leads to improved continuity, unified cross-system efforts, clear communication, and a more comprehensive approach to work with participants has been achieved.

The program was honored to receive the 2000 Exemplary Service Award from the King County Mental Health, Chemical Abuse and Dependency Services Division in the Service Innovation category. This recognition at the local level reinforces the perceived value of the program to the community, as well as the unique expertise the program provides in its work with participants.

The program has shared information, successes, and challenges in a number of ways this past year:

- ☐ The program is represented on the King County System Integration Advisory Committee, a work group that seeks to improve access to, and quality of, integrated mental health and chemical dependency services.

- ☐ Each calendar quarter, the program is presented to individuals from a broad array of organizations (criminal justice, inpatient, community mental health, drug/alcohol providers) from across the United States and Canada who visit King County to learn more about the continuum of care developed to address the needs of mentally ill offenders.

- ☐ Seattle Mental Health, the lead agency for the program, used the

expertise developed through this project and its involvement with the Dangerous Mentally Ill Offender program to develop a Forensic Mental Health Department. This department provides specialized services to individuals with mental illness who have also been involved with the criminal justice system (not just those served through special projects). In the last year, this department was awarded a contract to provide liaison staff to the City of Seattle Municipal and the King County District Mental Health Courts. These liaisons affect linkages with mental health and other providers, and provide ongoing communication to these courts on the transition of clients released to community settings. This department has also taken over a domestic violence program for court ordered perpetrators.

- ☐ Program staff continue to work with the King County Community Corrections Mental Health Advisory Committee, a cross-jurisdictional group that identifies solutions for the needs of the hardest to serve mentally ill offenders. This committee includes a federal probation officer, a mental health court probation officer, a mental health provider, a county designated mental health professional, a King County RSN representative and the supervisor of DOC Community Corrections Special Needs Unit.

- ☐ When hiring new staff to work with mentally ill offenders, both SMH and DOC include representatives from each organization and ancillary providers on interview panels.

- ☐ Program staff continue to participate in the King County Incarceration Work group, which works on resolution of problems between community and corrections staff, improved communications and procedures for developing collaborative treatment and discharge plans.

- ☐ Program staff continue to be available to King County treatment providers as trainers and case consultants.

Innovations

The program developed numerous innovations this past year that improved the range, availability, and appropriateness of services to participants.

- ☐ Use of Multi-System Care Plan for pre-release planning: The program has continued using the Multi-System Care Plan, developed for the Dangerous Mentally Ill Offender program, during

the past year. This tool improves overall documentation of the pre-release care plan. Of particular value is input from institution-based DOC staff that provides information and concerns about inmates prior to the first pre-release meeting.

☐ Protocol development: Two protocols used in day-to-day operations were developed.

- A wait list protocol became necessary when the program reached capacity last year. The program Selection Committee, comprised of representatives from King County, the mental health provider, the substance abuse provider, DOC community corrections staff, and DOC staff from referring prisons developed a draft priority criteria which was then submitted to the Oversight Committee. The Oversight Committee suggested minor modifications and approved the proposal, subject to review before the end of the year.

- The second protocol modifies contents of the referral package and cover sheet sent by the referring prisons. The changes reflect documents in current use, eliminates out of date documents and reflect a better understanding of the type of information needed to approve a referral and to provide appropriate information about a potential participant. These modifications were developed by the Selection Committee and approved by the Oversight Committee.

☐ Improved access to entitlements: The program participated in a work group, which included a local representative from Social Security that reviewed policies and procedures for access to entitlements for homeless and mentally ill people. The program continues to work with the Social Security Administration and the DSHS Economic Assistance Administration in ongoing efforts to address efficiencies related to entitlement access for program participants.

☐ The program added a number of new groups to assist the clients. In addition to co-occurring disorder groups, transition, problem solving, and Moral Reconation Therapy (MRT), the program added a woman's support group and an art therapy group.

☐ Resources for sex offenders: The program continues to be challenged in locating suitable resources, most particularly housing. Despite the increased number of enrolled sex offenders, the

program has been successful in meeting these challenges.

APPENDIX B: - EVALUATION AND PRELIMINARY OUTCOMES

This section details information about program participants, services and preliminary outcomes during the first four years of the five-year pilot. Consequently, these are interim results. At the end of the five years, the evaluation will compare program outcomes to those in the Washington Institute for Mental Illness Research and Training study of mentally ill offenders. This research, the Mentally Ill Offender Community Transitions Study (CTS), has tracked a cohort of mentally ill offender individuals released from Washington correctional facilities in 1996 and 1997. Some data from the CTS study, subsequently referred to as the Comparison Group, are included in this report. This study gathered data on mental health services utilization and criminal recidivism over a three to four year period. It represents baseline data on mentally ill offenders in Washington State prior to the implementation of specifically designed and coordinated interventions.

Program Participant Characteristics

Enrolled Participants

This section profiles mentally ill offenders accepted and enrolled as active participants in the program. Of the 66 individuals accepted, two individuals withdrew shortly after enrollment and limited services were provided. Consequently, the information in the balance of this report reflects data on the 64 participants enrolled before August 1, 2002, who have had significant program involvement. In Year I (September 1998 – July 31, 1999) 26 participants entered the program. Many continued into the second year. In Year II (August 1, 1999 – July 31, 2000) 11 individuals entered the program, and in Year III (August 1, 2000 – July 31, 2001) 14 more persons were enrolled. During the fourth year (August 1, 2001 – July 31, 2002) 13 additional persons were enrolled. Three of these Year IV enrollees had not yet been released into the community as of July 31, 2002.

Table 1.1 reports the gender of program participants. Thirty-eight program participants (59.4 %) are male and 26 (40.6 %) female. This compares to 92.7% male and 7.3% female within the Department of Corrections (DOC).

Table 1.1 Gender of Program Participants

Program Year Admitted	Male		Female	
	#	Percentage	#	Percentage
Year I	14	53.8	12	46.2
Year II	6	54.5	5	45.5
Year III	8	57.1	6	42.9
Year IV	10	76.9	3	23.1
Total	38	59.4%	26	40.6%

The mean age of participants at the time of release from prison is 36.6 years compared to 34.8 years for the general population at DOC. Table 1.2 displays the age range of program participants.

Table 1.2 Age of Program Participants at Release.

Age group	Year I		Year II		Year III		Year IV		Total	
	#	Percent	#	Percent	#	Percent	#	Percent	#	Percent
< 20	1	3.8	--	--	--	--	--	--	1	1.6
20-29	7	26.9	2	18.2	2	14.3	1	7.7	12	18.8
30-39	8	30.8	6	54.5	5	35.7	6	42.6	25	39.1
40-49	9	34.6	3	27.3	6	42.9	5	38.5	23	35.9
50-59	--	--	--	--	1	7.1	--	--	1	1.6
60-69	1	3.8	--	--	--	--	1	7.7	2	3.1
Total	26	100%	11	100%	14	100%	13	100%	64	100%

Table 1.3 details the racial background of program participants. Half (50.0 %) are minorities, compared to 29.2 percent within DOC. One-third of enrollees are Black/African American (29.7 %) compared to 22.5 percent within DOC.

Table 1.3 Race of Program Participants

Year III Enrollees	Year I Enrollees		Year II Enrollees		Year III Enrollees		Year IV Enrollees		Program Total	
	#	Percent	#	Percent	#	Percent	#	Percent	#	Percent
Alaskan Native/ American Indian	2	7.7	--	--	1	7.1	--	--	3	4.7
Asian/Pacific Islander	2	7.7	--	--	--	--	--	--	2	3.1
Black/Afro. Am	11	42.3	1	9.1	4	28.6	3	23.1	19	29.7
Hispanic	1	3.8	--	--	--	--	--	--	1	1.6
White/Caucasian	8	30.8	7	63.6	8	57.1	9	69.2	23	50.0
Other	2	7.7	3	27.3	1	7.1	1	7.7	6	10.9
Total	26	100%	10	100%	14	100%	13	100%	51	100%

Criminal History and Incarceration Characteristics

This section reports criminal characteristics and incarceration data. Table 1.4 shows the number of felony convictions for program participants. Three-fourths (75.0%) of program participants have been convicted of more than one felony. This compares to 77 percent of CTS comparison group subjects having more than one felony conviction.

Table 1.4 Number of participants with multiple felonies

Number of Felonies	Year I Enrollees		Year II Enrollees		Year III Enrollees		Year IV Enrollees		Program Total	
	#	Percent	#	Percent	#	Percent	#	Percent	#	Percent
One	9	34.6	5	45.5	1	7.1	1	7.7	16	25.0
Two	5	19.2	1	9.1	5	35.7	6	42.6	17	26.6
Three	8	30.8	2	18.2	2	14.3	2	15.4	14	21.9
Four	1	3.8	2	18.2	3	21.4	1	--	7	10.9
Five	2	7.7	--	--	2	14.3	1	7.7	5	7.8
Five +	1	3.8	1	9.1	1	7.1	2	15.4	5	7.8
Total	26	100.0%	11	100.0%	14	100%	13	100%	64	100.0%

Table 1.5 shows the types of crimes for which program participants were incarcerated. The index offense is the most serious crime for which the participant was incarcerated just prior to program involvement. This is not necessarily the most serious crime of record. Many program participants have more serious crimes in their histories. The index crime of nearly half (45.3%) of all participants enrolled in the program is a drug offense. The program admitted a much lower percentage of individuals incarcerated for drug offenses during the second year than during the first year. However, the percentage of third year enrollees incarcerated for a drug offense is closer to first year levels. The percentage of fourth year enrollees incarcerated for a drug offense is between the percentage for second and third year enrollees.

Table 1.5 Index Offense Characteristics of Program Participants

Index Offense	Year I Enrollee		Year II Enrollee		Year III Enrollee		Year IV Enrollee		Program Total		CTS (N=337)
	#	%	#	%	#	%	#	%	#	%	%*
Homicide/ Manslaughter	2	7.7	--	--	--	--	--	--	2	3.1	3
Sex Offense	1	3.8	1	9.1	1	7.1	2	15.4	5	5.9	14
Robbery/ Other Violent	7	26.9	4	36.4	3	21.4	3	23.1	17	26.6	24
Burglary/ Other Property	2	7.7	4	36.4	2	14.3	2	15.4	10	15.6	24
Drug Offense	14	53.8	2	18.2	8	57.1	5	38.5	29	45.3	29
Other	--	--	--	--	--	--	1	7.7	1	1.6	5
Total	26	100%	11	100%	14	100%	13	100%	64	100%	99%

*Reported percentages are rounded to nearest percent.

The most serious crime of program participants is reported in Table 1.6. Nearly 40 percent of program participants have committed a violent offense against a person at some time in the past. One-third (34.4%) have been convicted only of drug offenses.

Table 1.6 Most Serious Offense Characteristics of Program Participants

Most Serious Offense	Year I Enrollees		Year II Enrollees		Year III Enrollees		Year IV Enrollees		Program Total	
	#	%	#	%	#	%	#	%	#	%
Homicide/ Manslaughter	3	11.5	--	--	--	--	--	--	3	4.7
Sex Offense	1	3.8	1	9.1	1	7.1	3	23.1	6	9.4
Robbery/Other Violent	7	26.9	5	45.5	3	21.4	3	23.1	18	28.1
Burglary/Other Property	3	11.5	4	36.4	6	42.9	2	15.4	15	23.4
Drug Offense	12	46.2	1	9.1	4	28.6	5	38.5	22	34.4
Total	26	100%	11	100%	14	100%	13	100%	64	100%

The mean length of the index incarceration for all program participants is 25.7 months (Std D = 21.9.) The mean length of time of incarceration for participants enrolled in program Year II is 21.2 months (Std D = 11.1). This compares to a Year I average length of incarceration of 18.8 months (Std D = 16.5) (not including two extreme stays of 340 months and 285 months). Year III enrollees had an average length of stay of 36 months (Std D = 29.1) and Year IV enrollees who were released prior to July 31, 2002 were incarcerated an average of 32.6 months (Std D = 25.5) prior to release.

While all program participants received mental health treatment while incarcerated, the majority (71.9 %) required residential mental health treatment some time during their incarceration. The remaining (28.1 %) lived in the general population throughout their incarcerations. These figures are comparable to the 70 percent of CTS subjects who were treated in mental health units. For participants who required residential mental health treatment, the mean number of months in a DOC mental health unit is 12.2 (Std. D. = 14.1) months.

Mental Health and Substance Abuse Diagnosis

Table 1.7 reports the primary psychiatric diagnostic categories of participants at the time of enrollment, as diagnosed by the local mental health service provider. Comparison with CTS subjects is limited. The source of the CTS diagnosis is DOC personnel, the decision tree for diagnostic categories may differ somewhat, and the CTS study was unable to locate a diagnosis for approximately one quarter of subjects.

Table 1.7 Primary Psychiatric Diagnostic Categories of Program Participants

Diagnosis	Year I		Year II		Year III		Year IV		Total		CTS N=155*
	#	%	#	%	#	%	#	%	#	%	%
Psychosis	10	38.5	8	72.7	8	57.1	8	61.5	34	53.1	31.6
Depression	8	30.8	2	18.2	3	21.4	--	--	13	20.3	23.2
BI-Polar Disorder	7	26.9	1	9.1	3	21.4	4	30.8	15	23.4	34.2
Drug Abuse/ Addiction	1	3.8	--	--	--	--	--	--	1	1.6	--
Other	--	--	--	--	--	--	1	7.7	1	1.6	11.0
Total	26	100%	11	100%	14	100%	13	100%	64	100%	100%

*Known principal diagnosis by DOC

Clinicians diagnosed 23 of the 26 (88.5%) Year I participants as having co-occurring substance abuse disorders. Ten of the 11 (91%) participants entering the program in Year II have co-occurring substance abuse disorders. All Year III enrollees were diagnosed with a co-occurring substance abuse disorder and 11 of the 13 Year IV enrollees (84.6%) were diagnosed with a co-occurring substance problem. Overall, 90.6 percent of program participants are experiencing substance abuse disorders in addition to the primary serious mental illness. The largest percentage of persons is abusing both alcohol and other drugs.

A number of program participants carry personality disorder diagnoses as well as a major mental illness. Ten (38.5%) of Year I participants, eight (72.7%) of Year II participants, seven (50%) of Year III participants, and five (38.5%) of Year IV participants are dually diagnosed with a personality disorder. The overall figure is 46.9 percent. Nearly all (96.7%) of these participants with a major mental illness and a concurrent personality disorder have a co-occurring substance abuse disorder as well.

Program Services

Table 2.1 is a description of program services, providing information on the number of hours of direct service delivered to, and on behalf of, program participants between September 1998 and July 31, 2002. The individual treatment during pre-release usually includes DOC staff, program staff and the participant. These figures do not include specialized sex offender treatment services that an external private provider delivered, or travel time for case management staff.

Table 2.1 Program Service Hours (September 1998—July 31, 2002)

Service	Year I		Year II		Year III		Year IV	
	Pre release	Post release	Pre release	Post Release	Pre release	Post release	Pre release	Post release
Individual treatment								
Mental Health	58	1645	128	2209	211	1876	223	2270
Substance Abuse	--	45	5	168	15	166	10	231
Group treatment								
Mental Health	34	560	17	550	41	693	21	1312
Substance Abuse	--	369	--	324	34	854	18	273
Drop-in Center/ Day Treatment	4	482	--	619	--	947	--	792
Treatment Planning (SMH/DOC)	132	364	7	461	96	444	161	381
Special evaluations/ Consults	32	44	23	75	34	94	35	125
Med Management	--	44	--	103	6	75	2	102
Total hours	308	3668	163	4011	489	4829	470	5486

Near the end of the first year, the program added a staff member with expertise in co-occurring disorders (mental health and substance abuse) treatment. As a result, the table reports treatment hours by treatment focus (mental health or substance abuse). The table does not fully reflect the amount of substance abuse treatment hours program participants received, showing only those hours program staff provided. Some participants received additional hours of inpatient chemical dependency

treatment and/or service hours by other providers not under direct program contract.

Year III service data indicate a shift in focus of treatment services as compared to Year I and Year II. Fewer individual treatment services were replaced by increased group treatment services. Furthermore, an increase in individual substance abuse services from Year I to Year II continued in Year III. Group substance abuse treatment has more than doubled in Year III compared to Years I and II. The shift in balance of group treatment between mental health and substance abuse between years III and IV reflects a further change in programming. Integrated mental illness and chemical abuse (MICA) services are being delivered by mental health staff cross-trained in substance abuse services. These treatment services are being counted as mental health services in the system.

Outcomes

Meaningful Activity (Work, Education, and Other Structured Activity)

Table 3.1 presents information on meaningful activity on the 21 participants active in the program as of July 31, 2002. These activities are in a constant state of change; consequently, the activity of participants reflects their status at the end of July 2002.

Ten program participants were involved in some endeavor directed toward employment or pre-employment activity. Three participants were working part-time. One participant was in school part-time. One was engaged in volunteer work on a part-time basis and five were participating in Day Treatment on a full time basis.

Of those participants not involved in meaningful employment related activity, five were in pre-release status with DOC, or recently released and not ready for employment or educational activity. The remaining six participants were exhibiting adjustment problems that precluded vocational or educational activities. One participant was in intensive outpatient services for substance abuse treatment. One participant was in inpatient psychiatric treatment and four others were exhibiting adjustment problems that precluded regular meaningful activity, but did not warrant institutionalization.

Table 3.1 Meaningful activity as of July 31, 2002

Employment / Education / Training Status	**# of Participants**	
Employed part time	3	
Educational endeavor	1	
Volunteer activity	1	
Day treatment program	5	
Sub-Total	10	10
Pre-release and recent release status Sub-Total	5	5
Adjustment problem precluding meaningful activity		
Outpatient intensive substance abuse treatment	1	
Inpatient psychiatric hospitalization	1	
Other adjustment problem	4	
Sub-Total	6	6
Total		21

Housing

All program participants transitioned from pre-release incarceration into supervised housing arrangements. All received the program housing subsidy to support their housing costs. As of July 31, 2002, the 21 active program participants were living in a variety of circumstances. Three were still with the DOC on pre-release status. Nine were in the highly supervised, video-monitored Berkey House and three were residing in special sex offender housing. One individual had moved to a less intensely monitored group living environment and one had moved to independent housing.

Two participants were residing in congregate care facilities that were highly structured and supervised. One individual was psychiatrically hospitalized, and one individual was living in an environment considered inadequately structured. This individual had lost residence at the Berkey House for repeated rule violations, yet remains involved with program staff and treatment planning.

Financial Assistance

Table 3.2 reports the financial assistance for active program participants as of July 31, 2002. Three individuals were still in the custody of the DOC. All other active participants were enrolled with some form of financial support.

Table 3.2 Financial Assistance as of July 31, 2002

Financial Assistance	Frequency	Percentage
SSI	6	28.6
GAX	8	38.1
GAU	4	19.0
Not eligible/Pre-release	3	14.3
Total	21	100%

Medical Assistance

Participants apply for medical entitlements immediately after release. Table 3.3 reports these entitlements for currently active offenders.

Table 3.3 Medical assistance as of July 31, 2002

Medical	Frequency	Percentage
Medicaid	13	61.9
Medicare	4	19.0
Pre-release/Application not complete	4	17.4
Total	21	100%

Hospitalization

Table 3.4 displays information regarding psychiatric hospitalization of program participants. As an intervention to prevent further deterioration, 14 of the 61 participants released into the community have been hospitalized for psychiatric reasons. Four additional times, case managers would like to have hospitalized participants; however, they did not meet criteria for involuntary hospitalization. Of the 14 participants, one has been hospitalized seven times, another has been hospitalized five times, two have been hospitalized four times, one was hospitalized three times, three have been hospitalized twice and six participants have been hospitalized once. The large increase in the mean length of stay for years III and IV is primarily due to one individual who has required extended stays at Western State Hospital. This is the same individual with seven hospitalizations.

Table 3.4 Psychiatric Hospitalization

Program Year	# of Individuals	# of Hospitalizations		Mean Length of Stay in Days	Range of Stay in Days
		Voluntary	Involuntary		
I	5	7	--	9.3	4-16
II	6	7	3	7.0	2-21
III	4	5	6	14.5	2-69
IV	3	5	2	52.2	3-216
Total	18*	24	11	18.9	2-216

* represents individuals hospitalized in more than one year

Substance Abuse Relapse

This report defines a relapse very broadly as any episode of alcohol or non-prescribed drug use by a participant with a substance abuse diagnosis. A relapse may constitute a single drink or several days of continuous use. Data comes from a review of clinical records. Table 3.5 shows the number of relapses for participants during their active enrollment.

Table 3.5 Relapse of Participants with Substance Abuse Diagnosis

Number of Relapses	Year I Enrollees		Year II Enrollees		Year III Enrollees		Year IV Enrollees		Total	
	N	%	N	%	N	%	N	%	N	%
0	5	21.7	5	50.0	6	42.9	7	63.6	23	39.6
1-3	6	26.1	4	40.0	5	35.7	4	36.4	19	32.8
4-6	6	26.1	--	--	2	14.3	--	--	8	13.8
7+	6	26.1	1	10.0	1	7.1	--	--	8	13.8
Total	23	100%	10	100%	14	100%	11	100%	58	100%

Nearly two out of five participants (39.6 %) with a substance abuse disorder show no evidence of relapse while in the program. Year I enrollees relapsed most frequently. Among those persons enrolled in the first year of the program, four out of five have shown evidence of relapse. Analysis of the number of relapses indicates that Year IV enrollees have significantly fewer relapses ($F=2.87$, $p=.044$) than Year I enrollees.

Comparisons of the number of relapses are complicated, however. Participants have varying lengths of time in the program. Consequently, a rate of relapse for each group of enrollees was calculated based on the number of participant weeks. (Participant weeks is a concept analogous to man hours and is calculated by multiplying the number of program participants by the number of weeks each was in the program, post-release.) Rates of relapse are presented in Table 3.6.

Table 3.6 Rate of Substance Relapse by Year of Enrollment

Program Year	Year I Enrollees (N=26)		Year II Enrollees (N=11)		Year III Enrollees (N=14)		Year IV Enrollees (N=10)		Total (N=61)	
	Rate	SD	Rate	SD	Rate	SD	Rate	SD	Rate	SD
I	.08	.102	--	--	--	--	--	--	.08	.102
II	.03	.053	.02	.059	--	--	--	--	.03	.053
III	.07	.070	.004	.012	.02	.048	--	--	.03	.056
IV	.04	.084	.05	.091	.03	.059	.08	.085	.04	.074

The rate of relapse in Program Year I was .08 relapses per participant week. The Reporting Year II relapse rate was .03 and has remained steadily lower in subsequent years. Program Year III presents anomalous results, with Year I enrollees demonstrating a higher rate of relapse than other years and Year II enrollees demonstrating a much lower rate than previous and subsequent years. N's are limited and averages responsive to small variation.

Community Corrections Violations and Re-institutionalization

Of the 61 participants enrolled in the program and released to the community, 29 (45.5 %) have committed no community corrections violations. Table 3.7 details the number of violations and resulting incarcerations. Participants entering the program during Year I are responsible for 50 of the 81 violations (61.7 percent.) Depending on the severity of the violation and/or the number of violations, participants are incarcerated at the King County Jail or returned to the custody of the DOC.

Table 3.7 Community Corrections Violations & Violations Resulting in Incarceration

Enrollment Year	Number of Individuals with Violations	# of Violations	# of Resulting Incarcerations	Rate of Violations*	
				Mean	S.D.
I	19	50	32	.055	.066
II	3	11	4	.010	.022
III	6	16	11	.024	.043
IV	4	4	1	.025	.037
Total	32	81	48	.035	.053

*Based on number of violations per week of enrollment

Again, comparison between years of enrollment and program years benefit from the concept of participant week rates. Rates for persons enrolled in years II, III, and IV are less than half the rate for Year I.

Violation rates were also calculated for each of the program years. The rates of community corrections violations for the three years of the program are reported in Table 3.8. Violation rates for program years II, III, and IV are less than one-half the rate for year I.

Table 3.8 Rate of Community Corrections Violations by Program Year of Operation

Program Year I		**Program Year II**		**Program Year III**		**Program Year IV**	
Violation rate	S D	Violation rate	S D	Violation rate	S D	Violation rate	S D
.050	.068	.016	.026	.014	.022	.024	.035

Re-offense

Data on re-offense convictions is from the Washington State Institute for Public Policy database. The database is updated quarterly and results are based on data current through July 31, 2002. Results reported in this section are preliminary and include the 61 participants who have been released into the community as of this date.

Results of data on the most serious crime convictions post release by program participants are presented in Table 3.9, along with comparable data from the CTS study. Thirteen program participants have been convicted of 19 total felony offenses post release. Of the 19 felony offenses, one felony was for an escape, 10 felonies were drug offenses, six were crimes of property, and two felonies were crimes against a person. Four of the 19 felonies were committed by one individual, including both felonies against persons.

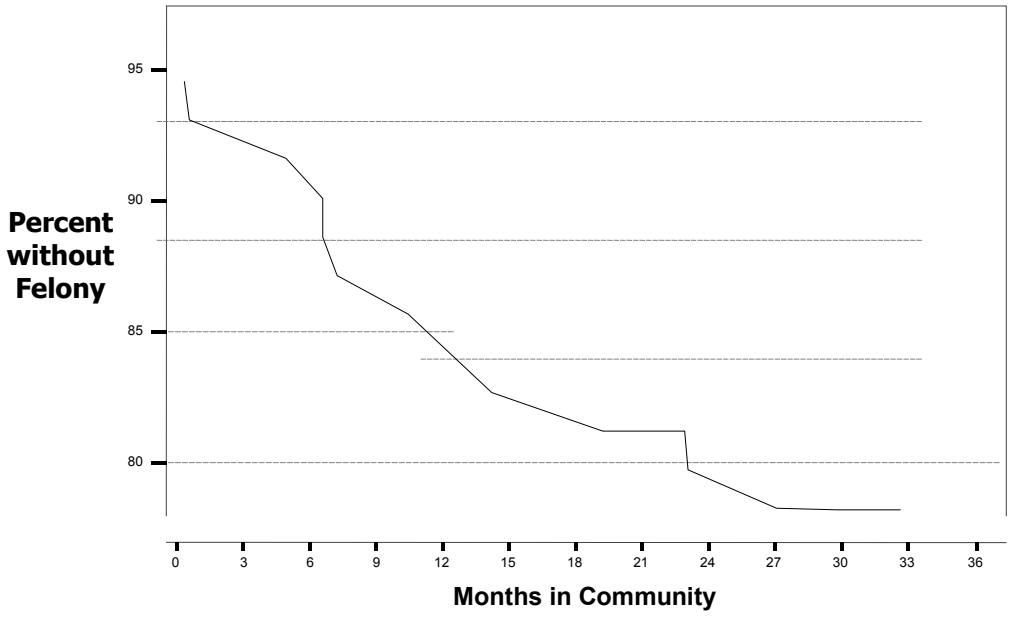
Table 3.9 Most Serious Offense Committed Post Release

Most Serious Offense	**N**	**Percentage of Convicted Program Participants**	**Percentage of all Program Participants (N=61)**	**Percentage of CTS Comparison Subjects (N = 333)**
Homicide/Manslaughter	--	--	--	**0.3**
Sex Offense	--	--	--	**0.6**
Robbery/Other Violent	**1**	**5.9**	**1.6**	**8.7**
Burglary/Other Property	**4**	**23.5**	**6.6**	**14.4**
Drug Offense	**8**	**47.1**	**13.1**	**15.3**
Other felony	--	--	--	**1.5**
Total felony	**13**	**76.5**	**21.3**	**40.8**
Misdemeanor	**4**	**23.5**	**6.6**	**20.0**
Total	**17**	**100%**	**27.9%**	**60.8%**

The length of time until a new crime has been committed is represented in Figure 3.1. Nearly two-thirds (61.5%) of new felonies were committed within the first twelve months of release. This compares to approximately 60 percent of CTS felonies that were committed within the first 12 months. Forty-eight of the sixty-one program participants released (70.0%) have been in the community more than 12 months. Thirty-five of the program participants (57.4%) have been in the community more than 24 months. Twenty-three participants (37.7%) have been in the community over 36 months.

The approximate shape of this curve appears consistent with results found in the recidivism literature and with results of the CTS study. A relatively steep drop begins to level at approximately 12 months from release and becomes nearly flat at approximately 24 to 30 months. Few new crimes are committed after this time period. Consequently, we can begin to have preliminary confidence in the shape of this curve and make a tentative prediction that the felony recidivism rate for the program participants will be less than 25 percent.

Figure 3.1 Community Survival Rate Until New Felony Conviction



The meaning of this rate becomes clearer in comparison to the CTS results of recidivism among mentally ill offenders who were released without specialized intensive mental health services. Appropriate comparison of recidivism rates, however, depends on the two groups' relative risk for recidivism. The CTS study found five variables, which predict felony recidivism at levels comparable to some of the best

prediction strategies reported in the literature. Four of the predictor variables (previous felonies, previous drug felonies, age of first offense, and felony versatility) were applicable to program participants. A comparison of predicted felony rates for program participants and the CTS group is presented in Table 3.10. Program participants have an average risk for felony recidivism (42.5%) that is very comparable to that of the comparison group (40.8%.)

Participants enrolled in the first three years and who have at least 12 months release time have a current recidivism rate of 25.5% (13 of 51.) There is some evidence that this recidivism rate may be high, and not reflective of current program impact. Eleven of the 13 participants convicted of a new felony (84.6%) were enrolled in the first year of the program. Seven of 26 (26.9%) Year I enrollees committed a felony within the first 12 months and nine (34.6%) had committed a felony by 24 months. This compares to one of 11 (9.1%) Year II enrollees, who have had at least 24 months in the community; and one of 14 (7.1%) Year III enrollees, who have had at least 12 months in the community.

Table 3.10 Comparison of Predicted Felony Recidivism Rates

Felony recidivism rates	**Mean for Program Group**					**Mean for CTS Comparison Group N=333**
	Year I N=26	Year II N=11	Year III N=14	Year IV N=10*	Total N=61	
Felony Prediction	40.6%	37.0%	52.5%	39.7%	42.5%	40.8%
Actual Felony Rate to date	42.3%	9.1%	7.1%	0.0%	21.3%	40.8%

* Less than 12 months in community

Consequently, there is good evidence to predict that second and third year enrollees will have a much lower rate of recidivism than first year enrollees, likely a result of program stabilization and improvements. To date none of the Year IV enrollees released has committed a new felony. Thus, preliminary results suggest that the Program recidivism rate will be as much as 50 percent lower than would be predicted. This reduction in recidivism may well be higher, particularly when considering the program stabilization and refinement that has taken place since the beginning of the project

Discharges

Of the 64 participants enrolled in the program, 21 were active at the time of this report and 43 have been discharged. Table 3.11 reports the reasons for discharge and reflects various levels of successful participation in programming. Several participants have requested less intensive services and made planned transitions to other mental health services.

While not considered graduations from the program, these individuals are considered successful at a lower level. Some participants have made unplanned departures from the program and have connected to alternative mental health services on their own. This is considered to reflect some measure of success as well, in that the participants are connected to mental health resources. Participants who withdrew from services in an unplanned manner without connecting to other mental health services, or withdrew from the program prior to release from the DOC are considered unsuccessful terminations.

Table 3.11 Program Discharge Information by Year of Enrollment

Reason for Discharge	Year I	Year II	Year III	Year IV	Total
Successful completion, graduated & transitioned	5	3	--	1	9
Planned withdrawal to less intensive services	5	2	5	1	13
Unplanned withdrawal, connected alternative service	2	2	1		5
Unplanned withdrawal, no services	10	2	1		13
Withdrawal pre-release	--	--	1		1
Not appropriate, misdiagnosed	2	--	--		2
Total	24	9	8	2	43

Summary of Evaluation and Outcomes

Participant characteristics, program services and preliminary results of evaluation and outcome data were presented for the first four years of the five-year project. Program services have remained consistently high over the course of the project, although the balance of group versus individual treatment, and mental health versus substance abuse treatment has shifted as a result of program changes.

Preliminary results of evaluation and outcome data reflect program stabilization over the course of four years and positive outcomes for program participants. Data in previous annual reports, and continuing in this report, have demonstrated an improvement in the rate of substance abuse relapse for participants during their subsequent years of participation and an overall improvement in the rate of relapse for the entire program, as compared to rates in the first year. Similar positive results have been demonstrated for community corrections violations.

More important, however, are the findings regarding re-offense at the felony level. The comparison group of offenders released in 1996 and 1997 had a recidivism rate of 40.8 percent. Factors that predicted recidivism were applied to the MIOCTP participants and these factors would predict a felony recidivism rate of 42.5 percent. To date, only 21.3 percent of program participants have committed a new felony. The large

majority of these (11 of 13) were first year enrollees, when the program was just beginning. Based on current programming, we estimate that program recidivism will be as much as 40 percent lower than would be predicted by comparison group data.

Conclusions and Recommendations

The results of this pilot program continue to be encouraging. While the outcomes are still preliminary, it appears that this model of providing intensive community services in a highly coordinated and integrated manner offers the promises of increased therapeutic services and increased community protection. The project has identified important program design elements and effective and therapeutic strategies. At the same time some barriers and resource gaps have become apparent. The three most significant barriers are housing, support systems, and medical problems. Addressing these barriers and resource gaps will improve service delivery, overall quality of the program and improve public safety.

While the data are preliminary and no final conclusions should be drawn, the preliminary findings are encouraging. These include:

- Community corrections violations rates were significantly reduced compared to the first year;
- Substance abuse relapse rates were cut in half when compared to the first year; and
- Felony recidivism reduced by 35 – 40 percent when compared to a similar offender group.

Recommendations include:

- Continue to fund this pilot project at current levels;
- Continue to explore innovative solutions to the identified major challenges; and
- Consider ways to provide the key model elements and the strategies to all mentally ill offenders.

Overall, the program has experienced growth in participant success, improved treatment programming, lower than predicted custody violations and substance abuse relapse, decreased recidivism, enhanced collaboration with other providers and agencies, and contributed to the safety and security of our community. We anticipate that the fourth and fifth years will continue to demonstrate the value and efficacy of the program.